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"DrinkThink" Alcohol Screening and Brief Intervention for Young People: a qualitative evaluation of training and implementation

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ABSTRACT

Background Alcohol Screening and Brief Intervention (ASBI) helps reduce risky drinking in adults, but less is known about its effectiveness with young people. This paper explores implementation of DrinkThink, an ASBI co-produced with young people, by health, youth, and social care professionals trained in its delivery.

Methods A qualitative evaluation was conducted using focus groups with 33 staff trained to deliver DrinkThink, and 8 interviews with trained participants and service managers. These were recorded, transcribed and a thematic analysis undertaken.

Results DrinkThink was not delivered fully by health, youth or social care agencies. The reasons for this varied by setting but included: the training staff received, a working culture that was ill-suited to the intervention, staff attitudes towards alcohol which prioritised other health problems presented by young people, over alcohol use.

Conclusions Implementation was limited because staff had not been involved in the design and planning of DrinkThink. Staffs' perceptions of alcohol problems in young people and the diverse cultures in which they work were subsequently not accounted for in the design. Co-producing youth focused ASBIs with the professionals expected to deliver them, and the young people whom they target, may ensure greater success in integrating them into working practice.

Key words: alcohol screening and brief intervention, co-production, implementation, facilitators and barriers

INTRODUCTION

Young people in the United Kingdom (UK) report some of the highest rates of heavy drinking in Europe [1, 2]. High intensity or binge drinking throughout adolescence is associated with numerous adverse health behaviours and outcomes, including anti-social behaviours and risky sexual practices [3-6]. English Chief Medical Officer Guidance [7] advises no alcohol consumption for those under 15 years of age, and no more than one day of alcohol consumption per week in young people aged 15-17 years, if at all. There have been some population level reductions in alcohol consumption among young people over the last 13 years [8, 9], but this has not been universal in terms of adherence to the recommended limits. Patterns of alcohol use among the young remain a public health and policy concern [10, 11].

Alcohol Screening and Brief Intervention (ASBI) has been developed primarily for use with adults but also young people attending primary care, college, or school settings; predominantly among higher age ranges of 18-25 [12-17]. There is little evidence to date on the effectiveness of ASBI delivered to young people in social care settings and those aged less than 18 years [13, 18-24]. Evidence from ASBIs used with adults in social service settings [25] suggests that expansion into young people's social care services might be appropriate; especially as young people are more likely to use community-based services [26, 27]. One ongoing evaluation of an alcohol screening tool for use with young people in the UK, is the Screening and Intervention Programme for Sensible Drinking (SIPS JR-HIGH) [28], which is assessing the effectiveness of ASBI delivered in schools to prevent hazardous drinking among 14-15 year olds.

In 2009, B&NES council initiated a service led intervention: DrinkThink, an ASBI designed specifically for use with young people with risky alcohol use. Training in DrinkThink is provided by Project 28: a young person's substance misuse service, to professionals working with 14-19 year olds in local health, youth and social care settings (See Box 1). The theoretical underpinning of DrinkThink encompasses motivational interviewing: a client-based approach used to address negative patterns of behaviour [29-31]. DrinkThink aims to support health and community workers identify when and how a young person's drinking might be hazardous and as a service-led initiative, falls within the remit of health, youth, and social care services, rather than specialist alcohol services. The value of ASBI undertaken by non-specialist services and staff is supported extensively in the literature [13, 26, 32-43].

Young people from Project 28 helped design the DrinkThink materials that include a series of flash cards with graphics showing drinking measures and units, a body diagram showing the impact of alcohol, and pictorial images with depictions of situations in which alcohol might pose a risk to young

people.

METHODS

This qualitative paper explores whether DrinkThink is acceptable and being delivered within young people's services, as intended. Two inter-related questions are addressed: 'is the DrinkThink training acceptable to professionals across health, youth, and social care service settings?', and 'is DrinkThink being delivered by professionals from health, youth, and social care service settings as intended?'

Participants

There were 4 participating agencies: a sexual health clinic, school nursing, and 1 youth and 1 social care service. Agencies were selected to ensure a range of settings were represented and staff selected according to their availability and whether they had received the DrinkThink training. Professionals who had received the training from 2013 onwards were eligible for inclusion. Excluded were agencies who had not received the DrinkThink training, or professionals working in adult services.

Focus groups and interviews

Focus groups were conducted with each of the 4 participating agencies and a total of 33 participants, arranged no less than two months after training had been delivered. Each group was organised and run by 2 researchers using a topic guide. Participants were asked open-ended questions about what they thought of the training; the content of the DrinkThink materials; whether they were implementing the DrinkThink intervention; and any views they had concerning the value of the intervention for their work. Opportunities were given to elaborate further on any related themes. The groups were audio recorded and transcribed before being coded.

An additional 8 interviews were conducted after 6 months to provide supporting evidence about why implementation was low; participants included 6 team leaders from the 4 participating agencies and 2 recently trained school nurses (see Table 1.). These interviews were conducted over telephone or email. Additional notes from correspondence, where relevant, and training observations were also included.

Analysis

Thematic analysis was conducted to identify and compare major themes across the different settings [44, 45]. Initial transcripts of verbatim, recorded interviews were scrutinised for themes by two researchers (JK and FF) and a coding frame of those themes devised. Subsequent transcripts were coded and the coding frame adapted or expanded as new themes emerged. All correspondence and meeting notes from other agencies which had not taken part in a focus group, but which had commented on use of Drink Think were also read and content noted where it related to the coding frame themes. JK and FF then developed the higher order interpretive themes based on the final coding frame, through discussion [46]. The additional interviews were conducted by JD and compared against previously identified themes.

MAIN FINDINGS OF THIS STUDY

Most staff participants were using elements of the DrinkThink intervention to conduct informal conversations, but few were delivering it in its entirety. Use of the Modified-Single Screening Question (M-SASQ) was sporadic and most staff relied on their own judgement about whether a young person required the intervention. Failure to implement the intervention in its entirety was due to factors that can be categorised according to three themes: 1) the training; 2) working 'culture'; and 3) participant's attitudes towards alcohol.

Training

Factual knowledge gained through the DrinkThink training was appreciated as it enabled participants to feel more confident; school nurses reported the training helped equip them to initiate conversations about alcohol and that it fitted easily into questions they were already asking about health. Follow-up visits by trainers were also helpful:

> "She does it as a reminder to bring it to the top of – because we deal with so many different issues, it depends who is hassling us the most (laughs) at the time." (School nurse, focus group)

Youth and social care participants however, felt unsure about how to practically implement the toolkit, even after training:

> "It was a PowerPoint presentation and it went through statistics […]. And at risk groups we looked at, and we looked at different types of alcohol, different units and effects of

that. And then right at the end we were given the pack. And we kind of looked at it and that was it, wasn't it?" (Youth worker, focus group)

For others, the training helped generate useful discussions about alcohol, but did not help in the delivery of the intervention:

"I mean it's always very different to get training in something and then to use it. So I think the training is, you know, good and it brings up a lot of discussion around young people and alcohol as well, which is always a good thing. But, yeah, looking at it in a reality of using it, can be slightly different, obviously, from receiving the training". (Youth worker, focus group)

Integration within work 'cultures'

Most participants selected the flash cards and body diagram to help initiate conversations about alcohol. Sexual health clinic nurses for example, incorporated elements of the toolkit within their existing assessment, when possible:

"Yeah, I don't tend to give the whole thing to them. It's more about a quick chat and then often giving them the tips, things to do to help with their problems, to take away with them. But quite often they've been in the clinic for a long time and they've come in for various other things - their sexual health, and then it's kind of like, we talk to them about drinking. And some of them will be open to it but a lot of them it's just like, "I want to go now. I've had enough," you know. So it is, it's the timing as well". (Sexual health nurse, focus group)

The complex nature of young people's problems could preclude fuller implementation of DrinkThink. For example, sexual health staff who deliver a 'walk-in' service, found the intervention competed with young people's other pressing health needs:

"But, you know, so much more now we've got domestic abuse, we've got sexual exploitation, we've got –there's so much. You know, we've got our core service and then there is so much that's coming in now that's potentially a knock-on effect. It's just, you know, how do you fit it all in sometimes?" (Sexual health nurse, focus group)

This was later confirmed by a team leader from the sexual health clinic who reported that although staff were positive about DrinkThink, they found allocating the necessary time to complete it, difficult:

> "I personally generally find the tool and the use of the brief intervention helpful, but the amount of time spent on this varies based on how busy the clinical session is. This seems to be the general feed-back from the team. You may recall that in addition to taking a full sexual history and doing a full-risk assessment for blood borne viruses, we also need to get medical, medication and allergy details, and enquire about smoking, recreational drug use and abuse – while aiming to fit in all this and the examination and dissemination of results in around 20 minutes, which proves quite an ask". (Sexual health clinician, interview)

Time was also raised by the school nurses' manager who reported that while staff appreciated the toolkit, they also had to implement a number of other interventions and DrinkThink had to 'compete' with these.

Youth and social care staff described their work culture as ill-suited to the DrinkThink intervention; commenting that it was "stilted" and "educational". This contrasts with their approach which is non-directive and engages young people according to their individual priorities and needs. A social care team leader described her teams' approach to addressing alcohol use as opportunistic:

> "To pull out a tool such as this in a session would arguably feel more formal than our approach to mentoring tends to be". (Social care team leader, interview)

> "I mean things like the drunk glasses, kids wearing drunken glasses is more interesting and engaging than the questionnaire […]. They remember it, it's quite experiential rather than academic. (Youth worker, focus group)

Youth and social care staff also noted practical barriers to the delivery of DrinkThink. Working in mobile settings, or other informal venues meant staff did not always have the DrinkThink materials with them, or that the venue was unsuitable. Youth workers discussed digital 'apps' as an easier tool to use in mobile settings:

> "I haven't got anywhere that I can easily access it, the actual cards and things. If I had like a smart phone app or something, if I had a smart phone rather than a tablet that I've got to put 48 passwords in to get in[…] But if I could just do that and just whiz through it, that would be really useful". (Youth worker, focus group)

Attitudes

Participants did not always perceive alcohol to be a significant problem among young people they saw. A youth team leader reported that of 20 new referrals received that month, only one was identified as having an alcohol problem. Other participants compared alcohol with other drug use, especially marijuana ("weed"):

> "I have to say, in terms of alcohol use, I really haven't met a young person yet that I've worked with where there has been real concerns about their alcohol use. Here it's more about smoking weed". (Youth worker, focus group)

Recent trends showing a reduction in alcohol use among young people ~~was~~ were influential in shaping staffs' views, implying that training had no impact on their views concerning the continued risks:

> "I'm surprised how little they drink, to be fair. Because I just think, I grew up in a bit of a drinking, eighties culture - I'm expecting them to be drinking far more, and I'm quite pleasantly surprised by their responses. And I think there is a general trend that young people are drinking less. I think they're all on their screens. They're not so – there's nobody drinking cider in the playground, in the parks much". (School nurse, focus group)

In addition to views held that statistically, young people were drinking less and that marijuana was more of a problem, there was also a lack of clarity about what constituted 'normal' and 'problem' alcohol use in the general population, whereby drinking alcohol was perceived as a 'social norm'. Several related their own experiences and distinguished 'normal' experiences of alcohol use, from alcohol use that leads to risky sexual practices:

> "I think it's the norm that young people go to uni or college and they go out and they drink. And I've done it, and most people have done it, and it's just normal. But obviously then there's the other side where they are having all these unpleasant sexual incidents, which I didn't do. So that's where you need to be picking up, then". (Sexual health clinic nurse, focus group)

> "I think equally it is the norm[…], because that is the norm: drinking and having sex is unfortunately the norm these days". (Sexual health nurse, focus group)

Alcohol was often evaluated in relation to other problems young people had. For example, a youth team leader reported that in her service, alcohol problems ranked behind mental health problems,

domestic violence, and drug use. Sexual health nurses saw their role as to address the sexual health needs of young people; drugs and alcohol were less of a priority:

> "I think we have to remember what we're here for, and that's to provide a service of sexual health screening and dealing with people's problems. Yes OK, alcohol could be a contributory factor to it, so that's important. But they actually want what they've come here for. And not to harangue them about the fact that they partied all night last week or whatever". (Sexual health clinic nurse, focus group)

In contrast, youth and social care teams reported routinely addressing alcohol use among young people, but according to their specific therapeutic aims and again, approach:

> "(There's) nothing wrong as such with the [DrinkThink] model. Our mentors tended to work in a person-centred, informal way with their mentees and be led by the mentees conversation. E.g. they'd talk about drinking if that arose in a mentoring conversation, and be led by their mentees wish to talk or not around it". (Youth team leader, interview)

DISCUSSION

Main findings of the study

DrinkThink, an ASBI designed to be used with young people, was not delivered as planned by health, youth, or social care staff. There was a general perception that alcohol was less of a problem among young people than either drug use or risky sexual practices. Work demands and the unsuitability of ASBI to the work culture of youth and social care services were also cited as barriers. Linked with this, some staff reported they already routinely address alcohol, using their own informal approaches. Most staff prioritised health issues according to the demands of their service and the types of problems presented by young people. Failure of the DrinkThink intervention can be attributed to a lack of appreciation of this diversity and the complex health issues presented. This was in part, due to lack of involvement of staff at the planning stage of DrinkThink. Issues concerning the different working cultures, time constraints impacting implementation, and staff's attitudes to alcohol could have been addressed earlier and additionally, influenced the design of the training.

What is already known on this topic

ASBI has been recommended for adults [27, 36, 51-53] and is currently under development for use with young people [28]. Secondary alcohol prevention work with young people under the age of 18 years is a less common approach than among adults [54]. Community-based agencies are more likely to see young people with health-related problems [8, 55, 56] and are therefore crucial to the delivery process [23].

However, the literature highlights several challenges in relation to secondary prevention in alcohol use. Healthcare professionals who perceive alcohol as a social 'norm', has meant that in some instances alcohol is not being addressed with patients [57-60]. For example, some professionals are fearful of damaging their relationship with patients [32, 43, 61-64]. Attitudes about role legitimacy, adequacy, and motivation towards addressing alcohol use, shows that staff can feel inadequate in providing what is sometimes viewed as a 'specialist' service [65]. These difficulties have been addressed in part, through the Short Alcohol and Alcohol Problems Perception Questionnaire (SAAPPQ) [66]. Additionally, the literature shows that structural constraints can limit effective implementation, especially high workloads against high expectations of the service and commissioners [67-69].

What this study adds

Public health interventions increasingly utilise co-production approaches in health programmes, but often with mixed results [70-73]. Findings from this study highlight the diversity of working environments and show that the absence of professionals at the planning and design stage of an intervention can have severe repercussions on outcomes. This study also emphasises the challenging nature of young people's experimental risk taking, such as; binge drinking, drug use, and risky sexual behaviour and consequently, the need for ASBIs to be adaptable to different contexts.

Limitations of this study

Focus groups and interviews with young people were initially intended to be part of the DrinkThink evaluation. However, insufficient young people were exposed to the intervention so our evaluation was limited to the health, youth, and social care professionals who had received training. SIPS JR-High is currently under evaluation [28] and will undoubtedly contribute to an increased understanding about the effectiveness, or otherwise, of ASBIs used with younger age groups.

CONCLUSIONS

ASBIs used with young people in community healthcare settings require a degree of flexibility and adaptability in both design and application. Involvement in the design of interventions from the outset would also enable opportunities to address attitudes of professionals towards alcohol. Co-production remains a challenging area that still lacks clarity in terms of practice; for example, who should be involved and at what stage [47-50]. By grounding an intervention in practice-based understanding of the multi-faceted needs of young people, ASBIs can potentially assist staff to address their complex health needs.

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